Division of Behavioral Health Services
and
Arizona State Hospital

ANNUAL REPORT
FISCAL YEAR 2002

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Submitted in Compliance with A.R.S. 36-3405 (a) (b) (c) and 36-209(e)

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Arizona Department of Health Services

~Leadership for a Healthy Arizona~

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VISION AND MISSION STATEMENTS

DIVISION OF BEHAVIORAL HEALTH SERVICES VISION STATEMENT

Leadership for a Healthy Arizona

DIVISION OF BEHAVIORAL HEALTH SERVICES MISSION STATEMENT

Creating partnerships for personal and community health

ARIZONA STATE HOSPITAL VISION STATEMENT

The Arizona State Hospital will meet the needs of our patients and other customers in collaboration with our community partners. We will continue to be a unique and valuable resource in the provision of specialized psychiatric treatment, rehabilitation, education and research. We will always strive to improve our performance.

ARIZONA STATE HOSPITAL MISSION STATEMENT

The Mission of the Arizona State Hospital is to restore and enhance the mental health of persons requiring psychiatric services in a safe, therapeutic environment

Description of the Division of Behavioral Health Services Delivery System

The Arizona Department of Health Services is the State agency responsible for public health education, prevention and treatment. The Arizona Department of Health Services is comprised of six major service areas, which report to the Director of the Department. The Division of Behavioral Health Services is charged with the responsibility of overseeing publicly funded behavioral health services. By the end of fiscal year 2002, 54,912 clients received behavioral health treatment services per month. During fiscal year 2002, 177,000 persons received prevention services. Expenditures totaled $571,056,384.00.

The publicly funded behavioral health system provides services to both federally eligible (Title XIX and Title XXI of the Social Security Act) and State-only populations. Behavioral health care services include the following:

- Prevention programs for children and adults,
- Services for children and adults with substance abuse and/or general mental health disorders,
- Services for children with serious emotional disturbance and
- Services for adults with a serious mental illness.

The Arizona Department of Health Services receives funding to operate the behavioral health system through a variety of sources including Title XIX Medicaid, Title XXI State Children's Health Insurance Program (KidsCare), federal block grants, state appropriations and intergovernmental agreements. Federal Title XIX and Title XXI funds may only be used for eligible persons as prescribed by the State Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS).

The State is divided into six geographic regions, called Geographic Service Areas. Each Geographic Service Area is assigned to a regional behavioral health authority. The Arizona Department of Health Services/Division of Behavioral Health Services manages the delivery system through five contracted Regional Behavioral Health Authorities and three Tribal Regional Behavioral Health Authorities. For Native Americans who live on a reservation, the Tribe has the option of:

(a) Entering into an Intergovernmental Agreement with the Arizona Department of Health Services to deliver behavioral health services on the reservation, with the reservation acting as its own regional behavioral health authority;
(b) Contracting with the local regional behavioral health authority to provide services; or
(c) Allowing on-reservation Tribal members to obtain behavioral health services either through Indian Health Service, or going off reservation to receive services.

Services provided to Arizonans include medical, rehabilitation, assessment, counseling, consultation, specialized testing, professional treatment, support, crisis intervention, inpatient, residential, day programs, and prevention.

Description of the Arizona State Hospital

The Arizona State Hospital ("the Hospital") is located on a 93-acre campus at 24th Street and Van Buren in Phoenix, Arizona. A component of the statewide continuum of behavioral health services provided to the residents of Arizona, the Hospital is the only publicly funded, 24-hour inpatient, state-operated psychiatric hospital serving the state.

As part of the Arizona Department of Health Services, the Hospital provides direct care to the most seriously mentally ill Arizonans who are court-ordered for treatment to its 335-licensed bed facility requiring a state supported tertiary level of inpatient hospitalization and rehabilitative care. The Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and is a Medicare reimbursable institution.

Treatment at the Hospital is considered the "highest and most restrictive" level of care in the state, and patients are admitted as a result of an inability to appropriately care for them in a community facility, or because of their legal status. Hospital personnel continually strive to provide state-of-the-art inpatient psychiatric and forensic care. The Hospital is committed to the concept that all patients and personnel are to be treated with dignity and respect. The average monthly census for Fiscal Year 2001 – 2002, for all patient populations, was 303 patients.

Authorized by A.R.S. 36-201 through 36-207, the Hospital is required to provide inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. While providing evaluation and active treatment, the Hospital is continually cognizant of the rights and privileges of each patient, particularly the patient's right to confidentiality and privacy.

The Arizona Department of Health Services is the state agency responsible for assessing and assuring the physical and behavioral health of all Arizonans through education, intervention, prevention and delivery of services. The Hospital is one of six major service units which report to the Director of The Arizona Department of Health Services, as does its community services counterpart, the Division of Behavioral Health Services.

Overall guidance for Hospital leadership is provided by the **Arizona State Hospital Governing Body**, which is chaired by the Deputy Director of The Arizona Department of Health Services/Division of Behavioral Health Services, a Hospital physician and a community representative.

As required in statute (A.R.S. 36-217), the **Arizona State Hospital Advisory Board** advises the Deputy Director of the Division of Behavioral Health Services and the

Chief Executive Officer of the Hospital in the development, implementation, achievement and evaluation of hospital goals and communicates special hospital or patient needs directly to the Office of the Governor. The Hospital Advisory Board consists of 13 governor-appointed members.

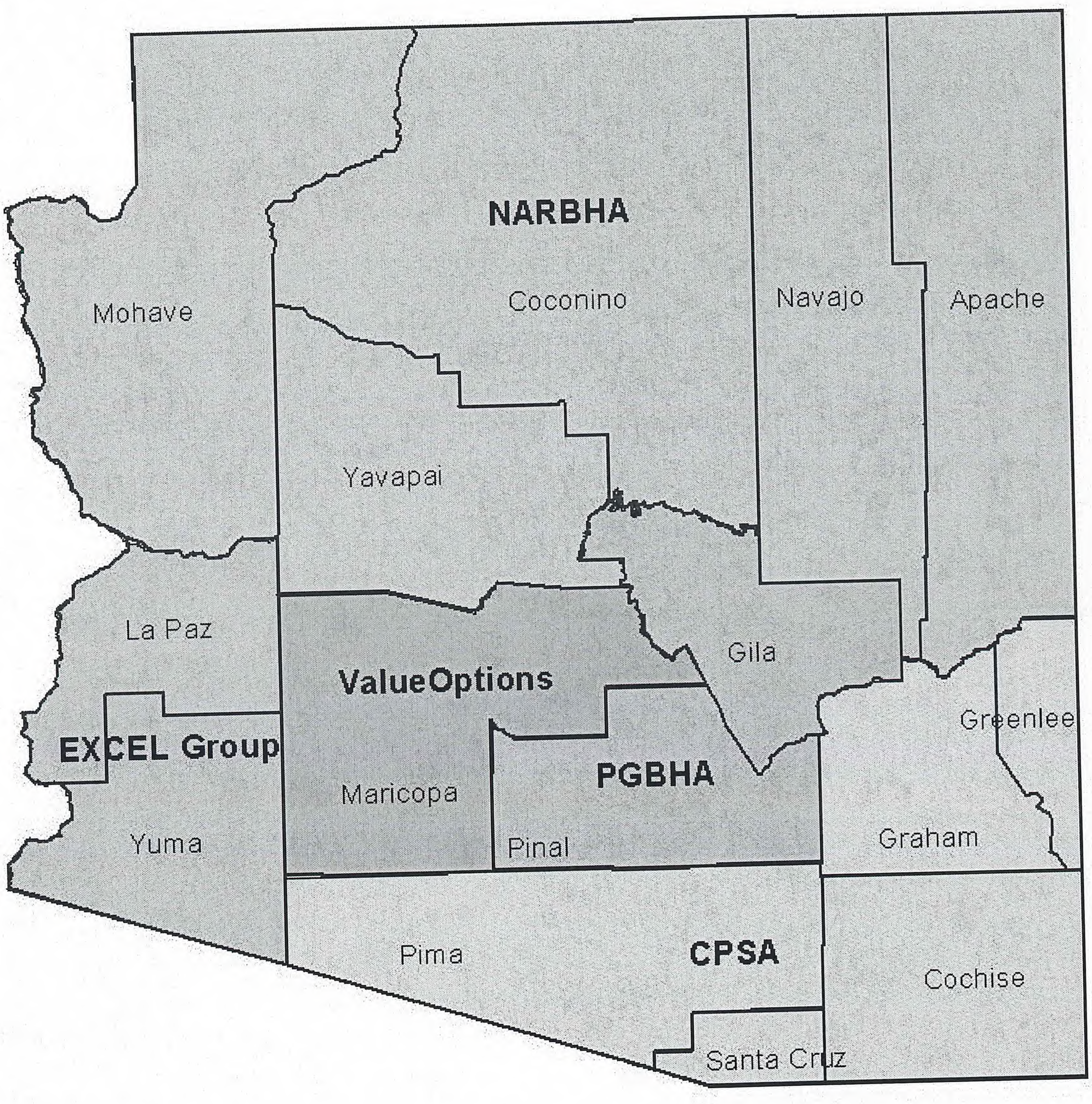
The Hospital receives overall direction from the Chief Executive Officer who reports to the Deputy Director of Division of Behavioral Health Services. The CEO supervises the leaders of the Hospital's four major divisions. These leaders include the Chief Medical Officer, the Chief Operating Officer, the Chief Quality Officer and the Chief Nursing Officer.

These Executive Management Team members oversee Hospital operations, establish administrative policies and procedures, and direct Hospital planning activities. Other Executive Management Team members include critical department directors, legal counsel, the public relations officer and others at the discretion of the Chief Executive Officer.

Geographic Regions

Geographic Regions

Figure 1



ORGANIZATIONAL STRUCTURE

Division of Behavioral Health Services

The **Deputy Director** provides leadership and direction in accomplishing the mission of the Arizona Department of Health Services/Division of Behavioral Health Services, works as a member of the Department's Executive Management Team, and oversees the Arizona State Hospital and community behavioral health system of care delivered through the Tribal and Regional Behavioral Health Authorities. The Deputy Director leads the Core Management Team of the Division.

The **Medical Director** provides medical guidance to the Deputy Director and to all Division bureaus and offices and to the Department Director through participation in the Physician Advisory Council. Working closely with the Medical Directors of the regional behavioral health authorities, the Medical Director develops clinical practice guidelines, standards and review instruments that are used throughout the State and maintains/updates drug and laboratory formularies. The Medical Director coordinates with the Medical Director of the Arizona Health Care Cost Containment System and with Arizona Health Care Cost Containment System health plans for the joint management of clients' physical and behavioral health needs.

The **Division of Clinical Services** provides clinical leadership, technical assistance and consultation to the Regional Behavioral Health Authorities ensuring conformance with federal and state regulations. Best practices are researched and guidelines are provided for the delivery of behavioral health services. Clinical Services is comprised of three Bureaus, Adult Services, Children's Services and Substance Abuse Treatment and Prevention.

The **Bureau for Consumer Rights** assists consumers in knowing, protecting and exercising their rights with respect to applying for and receiving behavioral health service, providing a grievance and appeal system available to consumers, contractors, and providers for the administrative resolution of disputes. The Bureau provides support to each regional Human Rights Committee through technical assistance, training, clerical support and problem solving. The Bureau is composed of the Office of Human Rights and Office for Grievance and Appeals.

Finance provides oversight and coordination of the Division of Behavioral Health Services financial and operational functions to ensure efficient, effective, and accountable operations in accordance with federal and state laws and regulations and Department policies. The Functions of the Bureau include fiscal monitoring and budget, provider services, procurement and personnel services as well as receiving incident reports of financial fraud and abuse. The Bureau has provided leadership in the development of financial standards to assure a healthy balance of the fiscal viability of the system and the needs of the clients it serves.

The **Office of Tribal Relations** provides program development, contract oversight and interface of the Tribes currently operating as a regional behavioral health authority. The Division currently has three Intergovernmental Agreements with the

Gila River Indian Community, Navajo Nation, and Pascua Yaqui tribes authorized to act as a regional behavioral health authority. An Intergovernmental Agreement also exists between the Colorado River Indian Tribes and the Department for the delivery of non-Title XIX services.

The **Bureau of Quality Management and Evaluation** provides leadership and direction in quality evaluation and improvement, utilization review, risk management and the development of outcome measurement reporting. The Bureau coordinates and/or conducts monitoring activities which reveal the operational, financial, and clinical performance of the behavioral health system and synthesizes monitoring findings with other administrative data to inform the Division's strategic plan, monitoring processes, indicators and tools, and contract content. The Bureau of Quality Management and Evaluation includes the functions of Quality Improvement, Research and Evaluation, and Business Information Systems.

The **Behavioral Health Applications Team** is responsible for the maintenance and development of information systems that support the Division. These systems work in coordination with the Regional Behavioral Health Authorities and the Arizona Health Care Cost Containment System to monitor and resolve Title XIX, Title XXI, and Non-Title XIX enrollment, assessments encounters (claims), and provider issues. A primary function is to develop and maintain the Client Information System application and database. This system tracks clients receiving behavioral health services in Arizona. In addition to the support of the Client Information System, the Information Technology Support team develops PC stand-alone applications to support business needs within various Division of Behavioral Health Services offices.

The **Office for Compliance** is responsible to support and coordinate strategic planning for the Division, Title XIX Certification of Community Service Agencies, behavioral health related rule-making, mental health disaster responses, audits conducted by the Auditor General, the annual Administrative Reviews of the Regional Behavioral Health Authorities, the annual operational and financial reviews conducted by AHCCCS, mutual business activities with the Arizona State Hospital, and implementation of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements.

Table 3

Statewide Funding by Program State Fiscal Year 2002		
Funding	**Amount Paid**	**Percentage**
TXIX Children	$ 97,659,764	17.42%
Non-Title XIX Children	$ 21,406,374	3.82%
Title XXI Children	$ 6,832,182	1.22%
Title XIX SMI	$ 207,432,039	37%
Non-Title XIX SMI	$ 112,778,018	20.12%
Title XIX – GMH/SA	$ 52,147,702	9.30%
Non-Title – GMH/SA	$ 46,266,203	8.25%
Non-Title XIX Prevention	$ 13,143,030	2.34%
[1]Other Programs	$ 2,906,584	0.52%

[1]Other includes Corrections Offender, Liquor Fees, Perinatal Substance Abuse/El Rio, PASARR, and third party payor claims processing.

Total Statewide Funding $ 560,571,897

The Arizona State Hospital
Financial Summary Fiscal Year 2001-2002

Funding Sources (General Operations Based on Budget Allocations):*	
Personnel Services and Related Benefits – General Fund	$ 28,304,900
All Other Operating – General Fund/Arizona State Hospital Fund	10,126,600
Non-Title 36 Revenue	150,000
Rental Income	526,185
Endowment Earnings	400,000
Patient Benefit Fund	81,000
Donations	20,000
Psychotropic Medications	63,500
Community Placement – General Fund	1,095,600
Community Placement Treatment – Arizona State Hospital Fund	5,609,200
Male Restoration to Competency	510,796
Self Care Unit	183,024
Total Funding	**$ 47,070,805**

Personnel Services and Related Benefits	$ 28,188,582
Professional and Outside Services**	6,285,188
Travel (In-State)	54,180
Travel (Out-of-State)	4,371
Other Operating	4,241,895
Capital Equipment	237,463
Assistance to Others	5,608,600
Total Cost of Operations	**$ 44,620,279**

Collections (Deposited to the General Fund):	
Patient Care Collections to the General Fund	$ 449,329
Patient Care Collections to Arizona State Hospital Fund (RTC)	6,081,374
Patient Care Collections to Arizona State Hospital Fund (Title XIX	1,319,374
Non-Patient Care Collections to the General Fund	1,909
Collections to Other Funds	19,615
Total General Fund Collections	**$ 7,871,601**

* Excludes Sexually Violent Predators Program

** Contract Physicians, Outside Hospitalization Costs, Outside Medical Services, and privatization of support services

Daily Costs by Treatment Program:***	
Medical Psychiatric	$ 437
Adolescent Treatment	656
Special Psychiatric Rehabilitation	465
Psychiatric Rehabilitation	401
Forensic – Restoration to Competency	409
Forensic – Rehabilitation	340
Average Daily Treatment Costs****	**$ 401**

*** Rates became effective 09/01/99. *****Weighted average based on the number of patient days and costs per program.

Number of Clients Served – State Fiscal Year 2002

Division of Behavioral Health Services

Table 5

	CHILDREN				SMI				NON-SMI							Totals Column
	T19	T21	Non-T19	Children Subtotal	T19	T21	Non-T19	SMI Subtotal	GMH T19	GMH T21	GMH Non-T19	SA T19	SA T21	SA Non-T19	Non-SMI Subtotal	RBHA Total
CPSA-3	852	66	272	1,190	479	0	351	830	725	0	198	470	0	494	1,887	3,907
CPSA-5	3,363	299	1,468	5,130	2,933	2	2,440	5,375	2,677	1	1,447	1,080	2	1,852	7,059	17,564
Excel	855	115	406	1,376	388	0	217	605	608	1	340	370	0	642	1,961	3,942
NARBHA	2,061	202	716	2,979	1,870	1	1,101	2,972	1,412	1	545	889	0	1,030	3,877	9,828
PGBHA	1,211	79	402	1,692	369	0	212	581	1,057	0	355	495	0	304	2,211	4,484
Value Options	9,971	849	3,214	14,034	8,235	1	5,899	14,135	6,933	3	3,328	4,350	0	6,290	20,904	49,073
Statewide Total	18,313	1,610	6,478	26,401	14,274	4	10,220	24,498	13,412	6	6,213	7,654	2	10,612	37,899	88,798

Arizona State Hospital

Census management is a daily challenge for the Hospital. Exceeding licensed capacity by just one patient on one unit for one day risks Medicare reimbursement status ($28M in federal dollars), Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") accreditation, and compliance with licensure regulations.

Pursuant to Laws 2002, Chapter 161, Senate Bill 1149, on or before August 1 of each year, the Deputy Director and the Hospital collects census data by population to establish the maximum funded capacity and a percentage allocation formula for forensic and civil bed capacity (Arizona Revised Statutes 13-3994, 13-4512, 36-202.01 and 36-503.03).

The Deputy Director notifies the Governor, the President of the Senate, the Speaker of the House of Representatives and the Chairmen of the County Board of Supervisors throughout the state of the funded capacity and allocation formula for the current fiscal year.

For Fiscal Year 2002, the funded capacity and allocation for the Hospital's licensed beds is as follows:

Civil Adult (41% licensed beds):		**138 Beds**
Forensic Adult (54% licensed beds):		**180 Beds**
○ Restoration to Competency	60 Beds	
○ Guilty Except Insane	98 Beds	
○ Not Guilty By Reason of Insanity	22 Beds	
Adolescent (Civil & Forensic; 5% of licensed capacity)		**16 Beds**
Medical Bed (reserved for infection control)		**1 Bed**
TOTAL		**335 Beds**

The law requires the Superintendent of the Hospital to establish a wait list for admission based on the date of the court order when funded capacity is reached in any population category. When funded capacity is reached, referring agencies are notified and the person is placed on the wait list until an appropriate bed becomes available. These persons remain in a community inpatient setting or a county jail psychiatric ward while on the wait list. During Fiscal Year 01/02, the Hospital found it necessary to implement a wait list for Adolescent and Pre-Trial Forensic Restoration to Competency Programs.

Population Shift

From October 1999 to November 2002, the Hospital has experienced an overall population shift. In October 1999, 51% of the Hospital's patients were civil admissions, 44% were forensic patients and 5% were adolescent patients. Today, the Hospital reserves 54% of its' beds for forensic patients, 41% for civil adult

patients and 5% for adolescent patients.

End of Month Census

The Hospital began Fiscal Year 2001/2002 with a patient census of 303 and ended the fiscal year on June 30th with a census of 314, an increase of 11 patients. During the year, 463 patients were admitted and 453 patients were discharged, of which 21 (4.6%) were administrative discharges to a medical facility. The average daily census for the fiscal year was 303 patients. These patients accounted for a total of 110,714 patient days*, a decrease of 1,060 days compared to the previous fiscal year. The patient end of month census covering July 2000 through June 2002 is depicted in Tables 6 A and 6 B.

Table 6 A

End of Month Census, Fiscal Year 00/01 through Fiscal Year 01/02

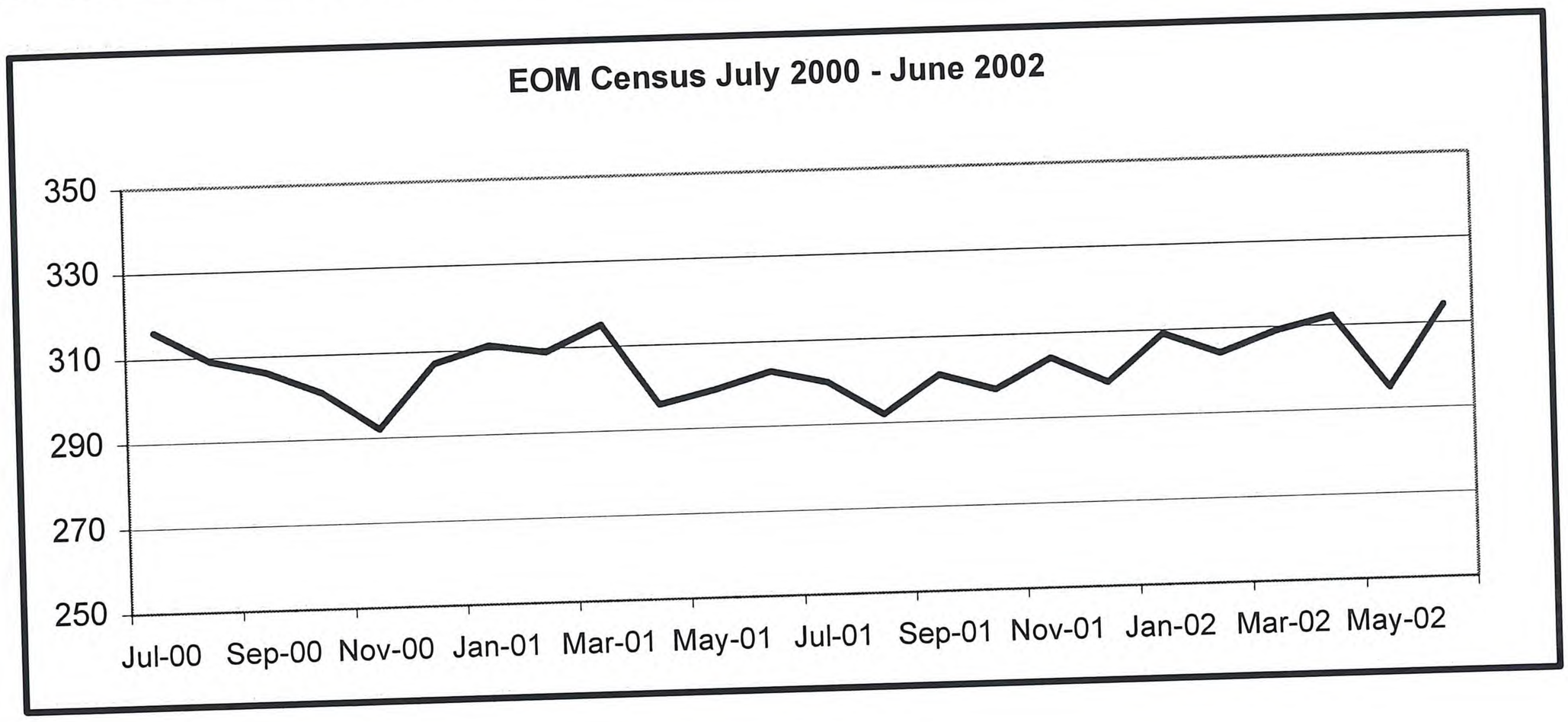


Table 6 B

End of Month Census Fiscal Year 00/01 through Fiscal Year 01/02							
Fiscal Year 2000-2001				**Fiscal Year 2001-2002**			
July	316	January	311	July	300	January	309
August	309	February	309	August	292	February	304
September	306	March	315	September	301	March	309
October	301	April	296	October	297	April	312
November	292	May	299	November	304	May	295
December	307	June	303	December	298	June	314

*Patient days are defined as a patient assigned to a unit, i.e. occupies a bed on that unit. The patient can be on pass and the bed day will be counted as "occupied" for that day.

SUMMARY OF ADMISSIONS AND DISCHARGES FOR THE ARIZONA STATE HOSPITAL IN FISCAL YEAR 2002

The Hospital admitted 463 patients this fiscal year, which included 19 (4.1%) returned from administrative discharge to a medical facility for a total of 444 non-administrative psychiatric admissions; 56 (33 readmissions within 180 days and 56 readmissions in general, for 7.4%) were readmissions after an average length of stay in the community of 169 days. Individuals admitted to the Hospital for the first time accounted for 322, or 72.5%, of all admissions during Fiscal Year 01/02. Admissions by diagnostic grouping indicated that patients diagnosed with schizophrenic disorders accounted for 42.5% (n=194) of all admissions during Fiscal Year 01/02, which is a 13.5% increase from 29% during the previous fiscal year. During Fiscal Year 01/02, patients diagnosed with affective psychoses (18.4%) and other non-organic psychoses (14%) comprise the major diagnostic groupings for patient admissions to the Hospital. The average monthly admission rate for Fiscal Year 01/02 was 38.6 patients, ranging from a low of 20 admissions in February to a high of 48 admissions in October. This was a 2.5% decrease from the Fiscal Year 00/01 average monthly admission rate of 39.6 patients.

Table 7
Monthly Admissions and Discharges

Fiscal Year 01/02	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Admits	40	36	40	48	47	22	40	20	38	46	42	44	**463**
Discharges	42	44	31	52	40	32	26	24	33	44	55	30	**453**

Table 8

Fiscal Year 00/01 Data:	
Beginning Census as of July 1, 2000:	307
Ending Census as of June 30, 2001:	303
Admissions 7/1/00 – 6/30/01:	475
Discharges 7/1/00 - 6/30/01:	479
Average Daily Census FY 00/01:	306
Average Monthly Census FY00/01:	303
Number of Patient Days:	111,774

Fiscal Year 01/02 Data	
Beginning Census as of July 1, 2001:	303
Ending Census as of June 30, 2002:	314
Admissions 7/1/01 – 6/30/02:	463
Discharges 7/1/01- 6/30/02:	453
Average Daily Census FY 01/02:	303
Average Monthly Census FY00/01:	316
Number of Patient Days:	110,714

Table 9
Admissions and Discharges by Population

	Total Admissions	Total Discharges
Adolescents:		
Forensic	36	31
Civil	4	4
Subtotal	**40**	**35**
Adult:		
Forensic	302	290
Civil	102	107
Subtotal	**404**	**397**
Total for FY 2002	**444**	**432**

Table 10

Adolescent admission and discharges

Forensic SMI Admissions		Civil SMI Admissions				Total
Title 13 – 4512	Title 8-242.01	Title 8 – 242.01	Voluntary	Title 14-5312	Title 36 -540	
RTC (tried as adult)	RTC	Civil Unspecified		With Mental Health Powers	Court Ordered Treatment	
1	8	27	1	1	2	**40**

Forensic SMI Discharges		Civil SMI Discharges				Total
Title 13 – 4512	Title 8-242.01	Title 8 – 242.01	Voluntary	Title 14-5312	Title 36 -540	
RTC (tried as adult)	RTC	Civil Unspecified		With Mental Health Powers	Court Ordered Treatment	
0	12	19	1	1	2	**35**

Adult admission and discharges

Forensic SMI Admissions					Civil SMI Admissions			Total Discharges
Title 13 –4512	Title 13-3994	Title 13-3994	Title 13-3994	Rule 31-226	Title 14-5312	Title 36 - 540	Voluntary	
RTC	GEI (dangerous)	GEI (non-dangerous; 75 day)	NGRI	Transfer of Prisoner	With Mental Health Powers	Court Ordered Treatment		
268	18	9	6	1	5	82	15	**404**

Forensic SMI Discharges					Civil SMI Discharges			Total Discharges
Title 13 –4512	Title 13-3994	Title 13-3994	Title 13-3994	Rule 31-226	Title 14-5312	Title 36 - 540	Voluntary	
RTC	GEI (dangerous)	GEI (non-dangerous; 75 day)	NGRI	Transfer of Prisoner	With Mental Health Powers	Court Ordered Treatment		
255	16	11	6	2	15	80	12	**397**

Figure 4

Legal Status At Admission Fiscal Year 01/02

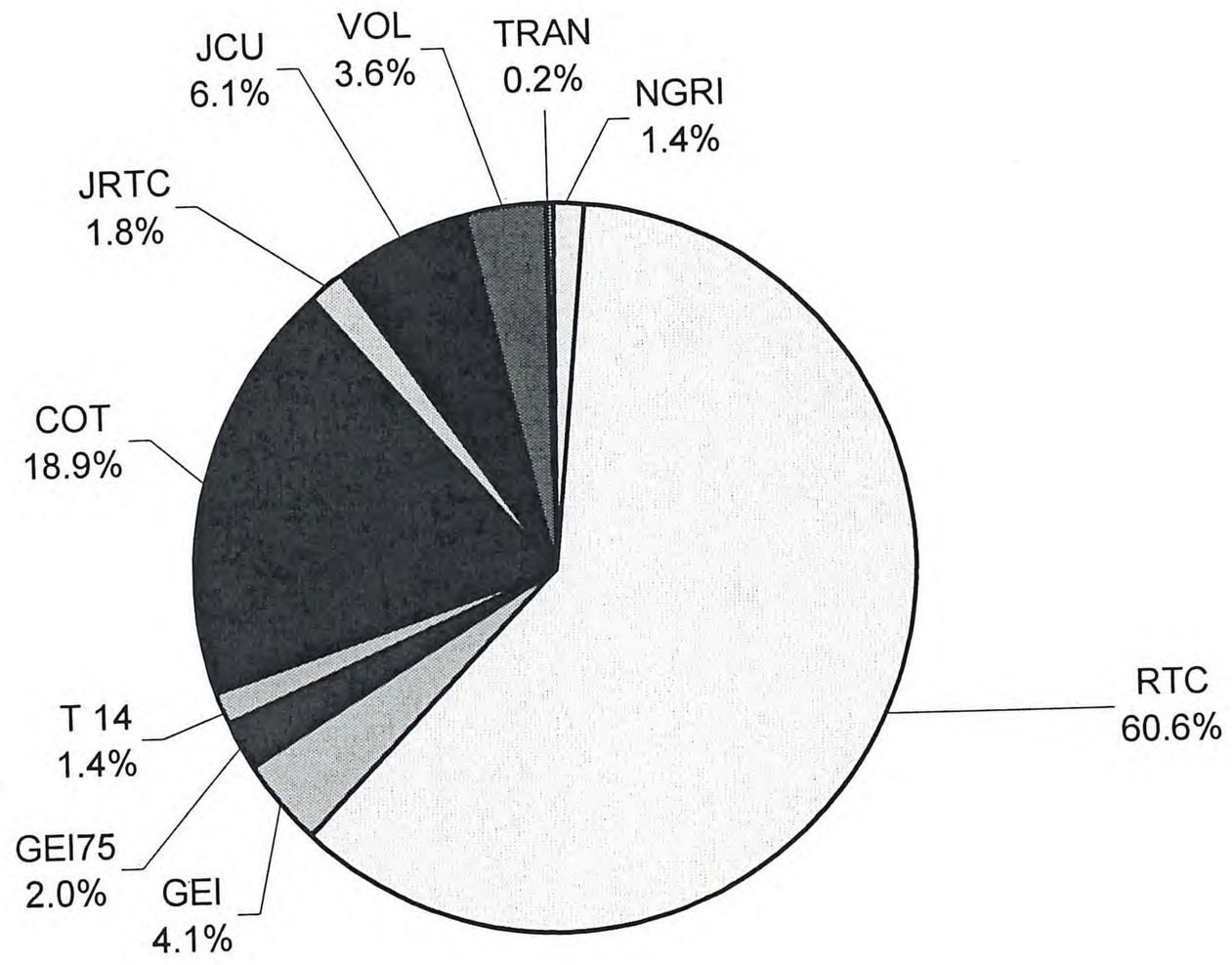


Table 11

Legal Status At Admission Fiscal Year 01/02

Code	Legal Status	Admits	Percentage
RTC	Title 13 – 45.12 Restoration to Competency (268 Adults; 1 Adolescent tried as an adult)	269	60.6%
COT	Title 36 – 450 Court-Ordered Treatment (82 Adults; 2 Adolescents	84	18.9%
JCU	Title 8 – juvenile Commitment – Unspecified	27	6.1%
GEI	Title 13 Guilty Except Insane	18	4.1%
VOL	Voluntary (15 Adults; 1 Adolescent)	16	3.6%
GEI75	Title 13 Guilty Except Insane 75 day	9	2.0%
JRTC	Title 8 – Juvenile Commitment – Restoration to Competency	8	1.8%
T 14	Title 14 with Mental Health Powers (5 Adults; 1 Adolescent)	6	1.4%
NGRI	Title 13 – 3994 Not Responsible for Criminal Conduct by Reason of Insanity	6	1.4%
TRAN	Rule 31-226 Transfer of Prisoner	1	0.2%
	Rule 11 – Observation	0	0.0%
	Title 36 – 547.04 Placement by Guardian	0	0.0%
	Title 13 – 45.07 Observation	0	0.0%
	Title 31 – 226F Petition for Transfer for Court-Ordered Treatment	0	0.0%
	Total Fiscal Year 01/02 Admissions	**444***	**100.0%**

*This figure does not include readmissions from administrative discharges to medical facility.

Admission by County

Maricopa County had the highest number of admissions during Fiscal Year 01/02 with 270 patients or 60.8% of all statewide admissions. Admissions from Maricopa County increased 17.4% from the previous fiscal year's total of 223 admissions. Pima County accounted for 73 or 16.4% of the total admissions. This was a decrease of 22.3% from last fiscal year's 94 Pima County admissions. The remaining thirteen counties accounted for 101 or 22.7% of the state admissions.

Recidivism:

Recidivism is defined as the readmission of a patient who was discharged from the Hospital within 180 days prior to the subsequent admission. The Fiscal Year 01/02 recidivism rate was 7.4% (n=33). Readmission rates for prior fiscal years vary from 4.4% in Fiscal Year 99/00 to 9.2% in Fiscal Year 98/99. In total, there were 56 readmissions during Fiscal Year 01/02 with an average community stay of 169 days before the subsequent admission in the Hospital.

Discharge Statistics:

The Hospital discharged 453 patients during this fiscal year, which included 21 administrative discharges to a medical facility.

Table 12

Admissions by County Fiscal Year 01/02

County of Admission	Total	Percentage
Apache	2	0.5%
Cochise	7	1.6%
Coconino	15	3.4%
Gila	9	2.0%
Graham	4	0.9%
Greenlee	2	0.5%
LaPaz	2	0.5%
Maricopa	270	60.8%
Mohave	13	2.9%
Navajo	5	1.1%
Pima	73	16.4%
Pinal	14	3.2%
Santa Cruz	3	0.7%
Yavapai	17	3.8%
Yuma	8	1.8%
Total Admissions FY 01/02	**444**	**100.0%**

Discharge Information

Table 13
Patients Discharged during Fiscal Year02 - Does not Include Administrative Discharges to MMC

Living Arrangements after Discharge	Adult	Adolescent	Total	Overall %
AWOL	2	0	2	0.46%
Correctional Facility	280	11	291	67.36%
Family	20	3	23	5.32%
Foster Home	3	1	4	0.93%
Group Home	28	2	30	6.94%
Homeless	7	0	7	1.62%
Independent Living	11	0	11	2.55%
Licensed Supervisory Care	5	0	5	1.16%
Non-Psych Hospital/Ward	5	0	5	1.16%
None	1	0	1	0.23%
Nursing Home	7	0	7	1.62%
Other	1	0	1	0.23%
Psych Health Facility	3	0	3	0.69%
Psych Hospital/Ward	8	4	12	2.78%
Residential SAP/SMI-Dual Diagnosis	2	0	2	0.46%
RTC 24-hour (not PHF)	15	4	19	4.40%
RTC Semi-Supervised (not PHF)	6	0	6	1.39%
Sponsored Based Housing	1	0	1	0.23%
Unknown	2	0	2	0.46%
Total	**407**	**25**	**432**	**100.00%**

Table 14

Discharge Length of Stay Fiscal Year 01/02

(Does not include patients discharged to a Medical Facility)

Length of Stay	Non-Forensic		Forensic		Total	
	Patients	%	Patients	%	Patients	%
Less Than 90 days	21	15.9	206	68.7	227	52.5
90 to 180 days	33	25.0	66	22.0	99	22.9
181 to 365 days	40	30.3	11	3.7	51	11.8
366 to 1095 days	29	21.9	8	2.6	37	8.6
1096 to 2190 days	5	3.8	7	2.3	12	2.8
2191 to 3650 days	2	1.5	2	.3	4	.9
Over 3651 days	2	1.5	0	0	2	.5
Total	**132**	**100%**	**300**	**100%**	**432**	**100%**

Table 15

Mean Discharge Length of Stay Fiscal Year 01/02

(Does not include patients discharged to a Medical Facility)

Length of Stay	Total Patients Discharged	Mean
Less than one year	377	97.75 days
More than 1 year but less than 3 years	37	589.3 days or 1.6 years
More than 3 years but less than 6 years	12	1533.67 days or 4.2 years
More than 6 years but less than 10 years	4	2338.5 days or 6.4 years
More than 10 years	2	4329 days or 11.8 years
Mean Discharge Length of Stay Total	**432**	**220.1 days**

Note: The mean discharge length of stay is the average number of days of hospitalization per patient during Fiscal Year 01/02.

Adult Discharges

Of the 432 patients discharged during this fiscal year, 397 or 91.8% were adults. Overall, the average length of stay for this age group was 226.9 days. During Fiscal Year 01/02, 109 non-forensic patients had an average length of stay of 458.1 days: 80 patients were discharged from the Title 36 Court Ordered Treatment program with an average length of stay of 502.2 days; 15 patients under Title 14 with Mental Health Powers were discharged in an average of 463.3 days; and 12 Voluntary patients were discharged in an average of 209.8 days. (Exhibit #7) During the same time period, 288 forensic patients were discharged with an average length of stay of 139.6 days: 255 patients were discharged from the Title 13 Restoration to Competency program with an average length of stay of 74.5 days; 16 Title 13 Guilty Except Insane patients were discharged in an average of 1010.9 days; 11 Title 13 Guilty Except Insane – 75 Day patients were discharged in an average of 37.8 days; and 6 patients were discharged from the Title 13 Not Responsible for Criminal Conduct by Reason of Insanity treatment in an average of 806.5 days.

Adolescent Discharges

Of the 432 patients discharged during Fiscal Year 01/02, 35 or 8.2% were adolescents. Overall, the average length of stay for this age group was 131.6 days. The 23 non-forensic patients stayed an average of 152 days during Fiscal Year 01/02: 19 patients were discharged from Title 8 Juvenile Commitment after an average of 143.7 days; 2 patients were discharged from the Court Ordered Treatment in an average of 155 days; a Title 14 with Mental Health Powers patient and a Voluntary patient were discharged in 225 and 134 days respectively. The 12 forensic patients – all Title 8 Juvenile Restoration to Competency – were discharged this fiscal year after an average of 76 days.

Civil - Adolescent: **A.R.S. 8-242.01** **Commitment**	Admission: $ A Parent (through the Superior Court) or custodian (as a ward of the state through Juvenile Courts) applies to the Hospital to have the child committed. $ The Hospital Medical Director evaluates the child and makes a determination
	Discharge: The patient achieves treatment goals as determined by the treatment team.
Forensic -Adolescent: **A.R.S. 8-242.01** **Juvenile Restoration to Competency** **Commitment**	Admission: These patients are juveniles who have been ordered by a juvenile judge to undergo treatment for restoration to competency or who have been found by a juvenile judge to need inpatient mental health treatment and the judge approves admission to the Hospital.
	Discharge: The patient achieves his/her treatment goals and the psychiatrist determines that the juvenile has been returned to competency.
Department of Health Services - Arizona Community Protection and Treatment Program **Admission & Discharge Criteria for Sexually Violent Persons as of February 9, 2001**	
Sexually Violent Persons (SVPs) **A.R.S. 36 - Chapter 37**	Admission: A competent professional evaluates certain inmates for SVP status near the end of their prison term(s). Based on the evaluation results, the county attorney may file a request for a Probable Cause Petition with the court. If the court determines probable cause exists, the inmate may be ordered for detention to the ACPTC program pending a trial (a pre-trial detainee), admitted for treatment or less restrictive treatment.
	Discharge: The patient must successfully pass a variety of psychological examinations and tests to indicate that he/she no longer poses a threat to the community. If no threat is posed, the ADHS Director or the Arizona State Hospital Chief Executive Officer may release the patient to a less restrictive setting (LRA) or to the community with supervision.

PROGRAMMATIC REPORT

Division of Behavioral Health Services

Covered Behavioral Health Services Expansion

During fiscal year 2002, the Arizona Department of Health Services/Division of Behavioral Health Services implemented an expanded comprehensive array of covered behavioral health services that assist, support and encourage each enrolled member to achieve and maintain the highest possible level of health and self-sufficiency. Toward this end, the Arizona Department of Health Services/Division of Behavioral Health Services aligned services to support a person and family-centered service delivery model, increased provider flexibility to better meet individual needs, included support and rehabilitative services provided by Title XIX Certified agencies, streamlined service procedure codes and provider types and increased service rates as well as capitation payments to the regional behavioral health authorities.

New support and rehabilitation services implemented in fiscal year 2002 include living skills training, health promotion, job coaching, supported employment assessment, pre-job training/education/development, out-of-office case management, personal assistance, family support, peer support, therapeutic foster care services, and out-of-home respite care. These same services plus targeted flex funds support a person and family-centered service delivery system.

Two new Title XIX Certified provider types were implemented to increase provider flexibility in the delivery of Title XIX compensable services: 1) Community Service Agencies and 2) Therapeutic Foster Care Home. The Community Service Agency solely provides support and rehabilitation services with the exception of case management. Therapeutic Foster Care Services are available for children and adults. Homes providing services to children are licensed as professional foster care homes by the Department of Economic Security, while homes providing services to adults are licensed by the Assurance and Licensure Division of the Arizona Department of Health Services.

An important part of expanding and enhancing the array of covered behavioral health services involved the streamlining of the behavioral health service procedure codes. Sixty-five plus service codes were eliminated in order to reduce redundancy and simplify billing. A handful of new codes were created for new Title XIX compensable services and old codes were made obsolete. This effort supports a streamlined billing process.

A capitation rate review and a service procedure code rate review were conducted for all Title XIX and state-only financed services. A Title XIX capitation rate increase for the regional behavioral health authorities became effective July 1, 2001. Service code rate increases were published on the Arizona Department of Health Services/Division of Behavioral Health Services Fee-For Service matrix which serves as a guide to the regional behavioral health authorities in setting behavioral health service code rates and is the rate used by the tribal regional behavioral health

authority Fee-For-Service subcontracted providers. The service code rate increase was the first since 1992. Service code rate assumptions are well documented and will serve as a basis for future rate setting endeavors.

Statewide training was conducted to a total of 1600+ stakeholders including regional behavioral health authorities, tribal regional behavioral health authorities, subcontracted providers, family members, consumers of service, advocates, the Department of Economic Security - Child Protective Services as well as the Division for Developmental Disabilities, the Administrative Office of the Courts, juvenile probation, the Department of Education, local school district personnel, and the public at large. Training and technical assistance will continue in the next fiscal year to support the full implementation of the covered behavioral health services array.

An the Arizona Department of Health Services/Division of Behavioral Health Services Covered Behavioral Health Services Guide complete with reference material was created for use by the regional behavioral health authorities and tribal regional behavioral health authorities and their subcontracted providers when designing service packages and clinical programs and in billing for services. The Guide and associated reference materials can be downloaded from the Arizona Department of Health Services/Division of Behavioral Health Services web site www.hs.state.az.us/bhs.

The Arizona Department of Health Services/Division of Behavioral Health Services Covered Behavioral Health Services include:

Treatment Services
- Counseling
- Consultation, Assessment and Specialized Testing
- Other Professional Services

Rehabilitation Services
- Living Skills Training
- Cognitive Rehabilitation
- Health Promotion
- Supported Employment Services

Medical Services
- Medication Services
- Laboratory, Radiology, and Medical Imaging
- Medical Management
- Electro-convulsive Therapy

Support Services
- Case Management
- Personal Assistance
- Family Support
- Peer Support
- Therapeutic Foster Care Services
- Respite Care
- Housing Support
- Interpreter Services

- Flex Fund Services
- Transportation

Crisis Intervention Services
- Mobile
- Telephone
- Urgent Care

Inpatient Services
- Hospital
- Subacute Facility
- Residential Treatment Center

Residential Services
- Level II Behavioral Health Residential Facility
- Level III Behavioral Health Residential Facility
- Room and Board

Behavioral Health Day Programs
- Supervised Day Program
- Therapeutic Day Program
- Medical Day Program

Prevention Services

Adult Services

At the 2002 fiscal year end, approximately 24,498 persons receiving services in the Arizona behavioral health system were classified as persons with a serious mental illness and 19,631 were classified as general mental health clients. The Bureau for Adult Services is responsible for the oversight and monitoring of the provision of behavioral health services by the Tribal/Regional Behavioral Health Authorities to persons with a serious mental illness and persons receiving services under the general mental health classification.

Adult Services staff serve as liaison to other state and community agencies by providing technical assistance and training in such areas as individual service planning, case management, provider management, and agency administration. In addition, Adult Services staff assist in resolving issues and complaints from consumers, family members, Tribal/Regional Behavioral Health Authority staff and community stakeholders. Adult Services staff directly responded to over 494 telephone calls, letters and legislative requests to facilitate the resolution of client and citizen inquiries about the behavioral health system.

Adult Services continues to have primary responsibility for the implementation of the court-ordered agreements in the Arnold vs. Arizona Department of Health Services lawsuit, commonly known as the Exit Stipulation and the Supplemental Agreement. Data is collected to monitor progress and the impact of the recent changes to Seriously Mentally Ill Determination. Efforts continue to expand service provision with the additional funds received from the legislature and through the Covered Services, House Bill 2003 (HB2003) and Proposition 204 initiatives. Adult Services

staff performed comprehensive data validation studies at the Regional Behavioral Health Authorities for the HB2003 legislative appropriations.

Adult Services plays an active role in obtaining, participating in, and/or managing federal grants related to services for persons with behavioral health needs. The development and expansion of vocational services also continued to be a high priority. The Division has participated in an intergovernmental Agreement with the Department of Economic Security/Division of Rehabilitation Services Administration in which state behavioral health funds are used to draw federal vocational rehabilitation funds to provide services for individuals with a serious mental illness. In addition, staff collaborate with other state agencies to expand the provision of vocational, housing, and other services to persons with serious mental illnesses by participating in multiple councils, boards, and advisory groups such as the Arizona Council On Offenders With Mental Illnesses, Interagency Service Agreement Advisory Board, Behavioral Health Planning Council, Arizona Behavioral Health and Aging Coalition and Arizona Coalition to End Homelessness.

The Division of Behavioral Health Services, Arizona Health Care Cost Containment System, and the Division of Economic Security/Department of Developmental Disabilities collaborated with community stakeholders in the development of a statewide Olmstead Plan. The Olmstead Decision requires that the state provide appropriate community-based services to meet the needs of the disabled person in the least restrictive environment. Adult Services staff are responsible for ensuring that the activities in the plan are completed. The Division of Behavioral Health Services staff applied for and received a grant to assist in the implementation of the Olmstead Plan and have contracted with a consultant to assist in developing discharge placements for persons with special needs who have been difficult to serve in community-based settings. In addition, Adult Services staff continue to serve as liaisons to the Arizona State Hospital and Tribal/Regional Behavioral Health Authorities in resolving issues that relate to admission or discharge of consumers.

The Pathways in Transition From Homelessness Project (PATH) – Adult Services staff continue to coordinate the services and activities provided through this federal grant from the Center for Mental Health. Outreach services are provided to persons with serious mental illness who are homeless, including those with co-occurring substance problems, in the three geographic regions with the largest numbers of homeless individuals. During Fiscal Year 2002, the PATH grant funded a comprehensive array of outreach and supportive services to more than 5,843 homeless persons across the state to identify homeless persons with serious mental illnesses.

The ADHS/DBHS Consumer Advisory Board For Persons With a Serious Mental Illness - With support from Adult Services staff, the Consumer Advisory Board coordinates an annual State Wide Consumer's Conference. Approximately 140 consumers participate in the conference. Bureau staff continues to facilitate the attendance and participation of consumers at other regional and national consumer conferences. During fiscal year 2002, Bureau staff assisted more than 20

consumers in attending conferences. In addition, travel and stipend support for consumers is provided to assist participation on various boards and councils, including the Statewide Advisory Panel on Integrated Treatment, RBHA consumer advisory panels, Behavioral Health Planning Council and Recovery Training workshops.

Children's Services

At the 2002 fiscal year end, approximately 26,401 children received services in the Arizona behavioral health system. The Bureau for Children's Services is responsible for the oversight and monitoring of the provision of behavioral health services by the Tribal/Regional Behavioral Health Authorities to children and their families.

On June 2, 2001, the Federal Court in Tucson approved a settlement agreement between the Arizona Department of Health Services and the Plaintiff's attorneys, in the class action lawsuit known as Jason K. The settlement ended 10 years of litigation focused on the delivery of behavioral health services to Title XIX eligible children in the state. Highlights of the agreement include the following requirements:

- Develop and Implement a Statewide Training Program
- Add Respite to the Array of Covered Services
- Create the Ability to Contract with Masters Level Specialty Providers
- Expand the Title XIX Services
- Designate $600,000.00 in Flex Funding
- Develop Practice Guidelines for Monitoring Medication
- Initiate the 300 Kids Project
- Change the Quality Management and Improvement System
- Involve Plaintiff's Counsel and Other Stakeholders
- Develop a Plan for the Expansion of Substance Abuse Services

Priorities for fiscal year 2002 included developing a statewide training program focusing on collaboration, assessment and service planning to ensure delivery of services consistent with the principles; fully implementing the 300 Kids Project and plans for replication throughout the state; expanding substance abuse services for children and developing practice guidelines for monitoring medications.

In June of 2002, all of the child-serving state agencies signed a Memorandum of Understanding adopting the following principles that continue to guide the system to the present day:

- Collaboration with the Child and Family
- Achievement of Functional Outcomes for Children
- Success in School
- Stable Lives with Families
- Avoiding Delinquency
- Preparing to Become Stable and Productive Adults

- Collaboration with Other Agencies and Multi-Systems
- Access to a Comprehensive Array of Services
- Delivery of Services in Accordance to Best Practices
- Services Provided in Home/Community Settings to the Extent Possible
- Timeliness of Services
- Services Tailored to Child/Family
- Stability is Essential: Minimize Multiple Placements
- Respect for Cultural Heritage
- Services Should Support and Train to Enhance Independence
- Utilize Natural Supports Available to the Child and Family

One of the primary elements of the Jason K Settlement Agreement was the establishment of the 300 Kids Project as a focused effort to engage in system improvement activities. Two sites were initially established, one in Maricopa county (200 Kids Project) and one in northern Arizona (100 Kids Project located in Flagstaff, the Verde Valley and in southern Navajo County). These sites tested strategies for providing behavioral health services in accordance with the 12 Arizona Principles and to serve as the first phase of the eventual statewide effort to deliver services according to these principles.

Flexible funds totaling $600,000 were allocated by the Division for the 300 Kids Project children, and early efforts to provide a wraparound service approach have been attempted with success even prior to the expansion of the array of available Title XIX covered services beginning October 3, 2001. Flex funding has now been allocated to all Regional Behavioral Health Authorities throughout the state effective July 1, 2001.

Training has been provided to staff at all levels in the project sites for the provision of flexibility and authority at the child and family team level for commitment of behavioral health resources for necessary home and community based services. Two hundred twenty behavioral health clinicians, case managers (including some from related State Agencies) and family participants have completed intensive training and have received coaching in child and family team practice to date with Vroon VanDenBerg (VVDB), LLP.

These practitioners are learning to use a highly individualized, strengths-based process for planning and support through child and family teams. Approximately 2,235 (duplicated count) individuals participated in various Vroon VanDenBerg, LLP training events in Arizona since May 2001, and over 700 more at several conferences co-sponsored by the Division.

The Maricopa County Regional Behavioral Health Authority, ValueOptions, has enhanced and developed a more complete training curriculum incorporating the Vroon VanDenBerg team facilitation training, internally developed content, and material from the Child Welfare Policy Group and from Karl Dennis, an internationally respected consultant. The Children's Intergovernmental Agreement Executive Committee established a standing Training Subcommittee in May 2002 to develop cross-system training processes and curriculum at a statewide level. The

Department of Economic Security Child Welfare Training Institute has also included curriculum complimenting the practice approach.

The Division collaborated with the Administrative Office of the Courts and the Maricopa County Juvenile Probation Department in the development of an evaluation, coordination and referral process for juveniles that are placed into detention at the Durango Court Center and the Southeast Juvenile Court Center. This joint effort is to ensure that detained juveniles in need of behavioral health services are able to have easy access to the behavioral health service delivery system. The project members continue to meet monthly for system monitoring and improvement issues.

The Division collaborated with Arizona Department of Juvenile Corrections on the development of a process for expediting referrals into behavioral health services for youth being discharged from correctional institutions and reintegrated back into their communities. This joint activity assists youth being released from institutions to obtain access to behavioral health services immediately upon discharge. This collaborative project is expanding throughout the state and involves all the Arizona Department of Juvenile Corrections correctional institutions.

House Bill 2003 funds were used in fiscal year 2002 to provide behavioral health services to children and families receiving services through the Division, Arizona Department of Juvenile Corrections, Department of Economic Security and the Administrative Office of the Courts. All Regional Behavioral Health Authorities have initiated programming under the House Bill 2003 funding, including implementing multi-agency teams, providing screening, assessments and/or outpatient services for Department of Economic Security, Administrative Office of the Courts and Arizona Department of Juvenile Corrections involved children, and construction of a team challenge course.

Model Court has been implemented statewide. It is a national movement that expedites juvenile dependency cases so that the amount of time children have traditionally spent in the State's foster care system is reduced, and a permanent plan that provides security, stability, and nurturing is quickly established. In each of Arizona's fifteen counties, the County Juvenile Court and representatives from the Department of Economic Security/Child Protective Services, Administrative Office of the Court, Legal Defender's Office, Office of Court Appointed Council, Public Defender's Office and the Attorney General's Office collaborate in monitoring the referral process and the coordination of appropriate behavioral health services for those children involved in Model Court cases and receiving Title XIX funded services.

Children's Services staff serve as liaisons to other state and community agencies, providing technical assistance and training. Children's Services staff are also directly involved in statewide efforts to implement the system reform efforts under the Jason K Settlement Agreement. Children's Services staff assist in resolving issues and complaints from family members, community stakeholders, Tribal/Regional Behavioral Health Authority staff and service providers.

Substance Abuse Treatment and Prevention Services

At the fiscal year end, approximately 18,268 persons with substance abuse conditions were served and during fiscal year 2002, 177,000 persons received prevention services in the Arizona behavioral health system. The Bureau for Substance Abuse Treatment and Prevention is responsible for the oversight and monitoring of the provision of behavioral health and prevention services aimed at reducing substance abuse problems and building resilient, substance-free families and communities in Arizona. Partnerships with affiliated agencies in criminal justice, mental health, child welfare, schools, and public and primary health care are fostered to ensure timely availability of treatment and prevention services.

The special needs of communities, high-risk populations, including women with young children, individuals with co-occurring mental health and substance disorders, offenders leaving prison settings and families involved in the child protective service system are addressed through practice leadership and guidelines. The management of the federal Block Grant for Substance Abuse Prevention and Treatment occurs through this functional unit.

The Division of Behavioral Health Services maintains active oversight of specialized programs for pregnant women and women with young children throughout Arizona. These programs, supported through the Substance Abuse Block Grant, ensure priority access to substance abuse treatment for pregnant women and support a statewide network of residential and outpatient services tailored to the needs of women with substance abuse disorders.

The Bureau continued its involvement on the Executive Advisory Board of the Arizona Substance Abuse Practice Improvement Collaborative, a coalition of treatment providers, consumers, universities and state agencies committed to promoting evidence-based practice in substance abuse delivery systems. During 2001-2002, the Practice Improvement Collaborative funded mini-research projects at four substance abuse treatment agencies, provided a five-month training session on motivational interviewing attended by 450 clinicians around the state and sponsored the third annual Bridging the Gap Substance Abuse Summer School in August 2002. Bridging the Gap featured presentations on substance abuse and disability, the Family Strengthening model, family-centered addictions treatment, cultural considerations and mini-workshops on a variety of evidence-based practices. Over 380 addictions professionals attended the summer school held in Sedona, Arizona.

A key accomplishment in the area of Prevention Services is the development and implementation of standardized core training for all community-based programs receiving Division of Behavioral Health Services Prevention funding.

The federally funded State Incentive Grant (SIG) resulted in a cooperative agreement among the Governor's Division of Drug Policy, the BSTPS and the Center for Substance Abuse Prevention (CSAP). As part of the Secretary of Health and Human Service's Initiative on Youth Substance Abuse Prevention, the primary focus of the SIG is to prevent marijuana use among youth ages 12 – 17, with an

Assessments are updated annually to provide a summary of the patient's treatment over the course of the year and to identify the patient's treatment needs for ongoing treatment and rehabilitation. Comprehensive assessments include, but are not limited to, information about the presenting problem and prior treatment, medical history/current medical condition; risk assessment; cultural, religious and spiritual issues; linguistic needs; and family/social history.

The information is used to evaluate and plan for the psychiatric, psychological, medical, rehabilitation and psychosocial treatment needs of the patient during hospitalization.

Methods of collecting information include record review; observation; psychological testing (as necessary); self-report and interview with family or outpatient service providers. The assessment includes the strengths and preferences of the patient in the areas of living, learning, working and leisure skills. Each discipline is expected to complete the initial assessment within the following time frames:

- **Nursing** – Within 8 hours of admission; repeatedly annually
- **Psychiatry and Family Practice Medicine** – Within 24 hours of admission; repeatedly annually
- **Social Work** – Initiated within 24 hours of admission and completed within 10 days following admission; repeated annually
- **Rehabilitation Services** – Within 10 days following admission; repeated annually
- **Nutrition Services** – Within 24-72 hours per guidelines in hospital policy; repeated annually.

Individualized Treatment and Discharge Plan (ITDP)

Upon completion of the comprehensive assessment, an Individualized Treatment and Discharge Plan is developed for the patient that considers the patient's identified assets and strengths, evaluation and treatment needs, and any barriers to the achievement of treatment goals for the patient.

Patient care treatment planning goals are geared to help each patient to achieve the highest level of individual functioning possible and to facilitate the return of the patient to less restrictive treatment alternatives in the community. The interdisciplinary clinical team reviews and revises the patient's Individualized Treatment and Discharge Plan ("ITDP") to ensure that appropriate treatment and placement continue.

The Individualized Treatment and Discharge Plan incorporates the results and recommendations of discipline specific evaluations and seeks to address the patient's biological, psychological, spiritual, cultural, linguistic and socio-economic needs. The patient's psychiatrist, who provides leadership for the clinical team (psychiatrist, social worker, nurse and a psychologist, as needed) coordinates the

patient's care and ensures there is a well-defined plan in place that may include these components:

- A full medical and psychiatric assessment of each new patient and at least annually re-written, with monthly clinical team reviews
- Medical care up to community standards for any medical condition, either acute or chronic
- Pharmacotherapy
- Psychotherapy (individual and group)
- Behavioral/cognitive therapy
- Full range of psychiatric rehabilitative therapy
- Family evaluation and therapy education process
- Recreational therapy
- Educational therapy (medication, coping skills, GED)

Throughout a patient's treatment, the Hospital strives to facilitate placement in the least restrictive and most appropriate therapeutic environment after discussion with the appropriate community behavioral health system service providers to assure that the chosen placement provides maximum therapeutic benefit for the patient. The Hospital is cognizant of its responsibilities to patients, their families and the community.

In order to provide quality care for patients, Hospital personnel actively participate in the statewide continuum of behavioral health care, coordinate the development of the patient's individualized treatment and discharge plans and encourage patient placement in alternative community programs in collaboration with community service providers as soon as the patient is adequately prepared for placement.

STAFFING

Staffing patterns vary depending on the acuity of the treatment program and individual treatment unit and the needs of the individual patients. Each unit is staffed with Registered Nurses, Clinical Nurse Specialists, Licensed Practical Nurses, Mental Health Program Specialists, Social Workers, Rehabilitation Specialists, Psychologists, Psychiatrists, Medical Physicians and Clerical Staff.

TREATMENT PROGRAMS:

The Hospital operates three major population-based programs:

- Civil Adult Rehabilitation Program (6 treatment units)
- Forensic Adult Program (3 specialized programs housed on 6 treatment units)
- Adolescent Treatment Program (1 treatment unit)

THE CIVIL ADULT PSYCHIATRIC REHABILITATION PROGRAM

The **Civil Adult Psychiatric Rehabilitation Program** consists of six treatment units that serve as admission, treatment and discharge units, although patients may be transferred from one treatment unit to another based upon the patient's special needs. Upon admission, patients are acutely psychotic and may be exhibiting self-injurious or threatening/aggressive behaviors.

These treatment units specialize in providing services to the seriously mentally ill patients who are civilly committed as a danger to self, danger to others, gravely disabled and/or persistently and acutely disabled; those who are placed at the Hospital by guardianship; those who are in the process of transition to community placement; and/or the seriously mentally ill patients who also have special medical needs. Treatment and medical management focuses on providing a safe and secure therapeutic milieu. The reduction or amelioration of psychotic symptoms or depressive symptoms is addressed through the use of medication and rehabilitation services.

Treatment modalities include medications and medication education, psychiatric rehabilitation and individualized group therapy, structured unit activities, leisure planning and recreational therapy; and community-based programs. Emphasis is placed on activities of daily living since many patients have deficits that impede their capacity to live more independently in community settings.

GROUP THERAPY DESCRIPTION for the Civil Adult Rehabilitation Program

- **Symptom Management** – designed to help patients, disabled by a chronic mental illness like schizophrenia, become more self reliant in managing their psychiatric symptoms. Major components include identifying warning signs of a relapse; managing warning signs; coping with persistent symptoms and avoiding alcohol and street drugs.

- **Medication Management** - designed to help patients disabled by a chronic mental illness become progressively more self-reliant in their use of anti-psychotic medication. Major components include obtaining information about anti-psychotic medication; knowing correct self-administration and evaluation of mediation; identifying side effects of medications; and negotiating medication issues with health care providers.

- **Basic Communication Skills** – designed to provide the basic patient with the basic skills needed to start friendly conversation, keep them going and end them pleasantly. Major components include verbal and nonverbal communication behaviors and putting all these activities together.

- **Recreation and Leisure Education** – designed to help a wide range of people in all age groups become more self reliant and resourceful in the use of their

leisure time. Major components include identifying benefits of recreational activity; getting information about recreational activities; finding out what is needed for a recreational activity; and evaluating and maintaining a recreational activity.

THE FORENSIC TREATMENT PROGRAMS

The Hospital's **Forensic Treatment Programs** consists of three specialized programs: the **Pre-Trial, the Post-Trial and the Community Reintegration Programs**, described in the following sections in more detail. The six treatment units each serve as an admission, treatment and discharge unit, although patients may be transferred from one treatment unit to another, depending upon special needs.

The forensic program provides for the evaluation and treatment of patients who have been court-ordered for pre-trial evaluation and restoration to competency (RTC) to stand trial; treatment for those adjudicated as guilty except insane (GEI) and court-ordered to the hospital; or those adjudicated as not-guilty by reason of insanity prior to January 2, 1994 or transfers from a psychiatric prison.

Patients with a potential for violent or dangerous behavior, patients with a high escape risk and patients with legal requirements on placement also receive treatment within these programs. Major treatment modalities include pharmacotherapy, psychological services and extensive assessment, psychiatric rehabilitation and substance abuse treatment, psychotherapy focusing on participating in treatment, interpersonal skill development, educational services for patients requiring restoration to competency, specific discharge plans and goal development. Each treatment unit provides a secure environment for various additional therapeutic activities with limited off-unit privileges granted on an individual basis.

GROUP THERAPY DESCRIPTION for the Forensic Programs:

- **Social Work Core Group**: Develops a rational understanding of the patient-defendant's legal situation, applying previously learned competency materials using legal case scenarios.

- **Individual Intervention:** Social Workers meets with the patient individually to needs toward reaching competency, such as understanding police reports and communicating with the attorney.

- **Nursing** provides programs to educate patients and promote skills for self-management of psychiatric illness (symptom management, potential side effects and negotiating medication issues as well as programs to teach patients their rights, legal pleas and court proceedings. Structured and creative use of leisure time is provided to promote overall psychological well being of patients.

- **Rehabilitative groups** designed to provide patients with basic skills to develop rational understanding of court related terms/concepts; development of coping skills, social/communication skills, improving self-esteem and increasing awareness of substance abuse issues.

THE PRE-TRIAL FORENSIC PROGRAM
(*Restoration to Competency Program "RTC")*

This forensic treatment program consists of three treatment units. Evaluation and/or treatment of patients referred to the Pre-Trial Forensic Program focuses almost exclusively on the issues identified by the courts in the individual's commitment order. Primarily, this relates to the symptoms and/or deficits that limit a defendant-patient's competence to stand trial. Any other treatment or services is either supplementary or coincidental. The average length of stay for patients discharged in Fiscal Year 2002 was 74.5 days.

Upon admission, each defendant-patient is assigned a staff psychiatrist, a social worker and a forensic evaluator (psychologist or psychiatrist). The interdisciplinary clinical team follows the individual until his/her discharge. After the initial evaluation and satisfactory psychiatric stabilization, male defendant-patients are transferred to other step down units.

Standard therapeutic components of the Pre-Trial Program include:

- Treatment of the psychiatric systems that interfere with the defendant-patient's ability to understand the court process and criminal charges
- Ability to assist in his/her own defense
- Understanding various educational measures geared towards promoting the individual's knowledge and understanding of his/her clinical and legal issues

Treatment is accomplished via a variety of educational and therapeutic groups, along with written materials, video sessions, games, puzzles, art projects and other recreational activities.

Psychiatry is responsible for a defendant-patient's overall psychiatric assessment and treatment. The psychiatrist contributes to or submits reports to the courts and testifies when necessary.

Psychology conducts forensic evaluations and submits court reports on a regular basis and testifies as necessary. Psychologists also provide consultative and/or psychological testing services when requested, but not on cases they are assigned to as forensic evaluators.

Nursing is responsible for delivery of and feedback about prescribed medications, as well as ongoing observation and documentation of the defendant-patient's daily

functioning. Nursing actively participates in educational and therapy groups and provided individualized care, support and intervention, as needed.

Social workers communicate with the courts, attorneys, jails and other agencies coordinating the patient's admission to, and discharge from, the Hospital. Social workers obtain prior records and background data relevant to the program's mission.

Rehabilitation therapy provides art, music and recreation therapy groups for evaluation and treatment. In addition to assigned treatment groups, Rehabilitation therapy services provide therapeutic activities for both rehabilitation and as an opportunity for staff to observe for features of inconsistent presentation (possible malingering).

The unit manager provides a safe, therapeutic environment and supplies patients with clothing, personal use items and other physical necessities while in the program.

Each defendant-patient admitted to the program is assigned a family practice physician for medical care, routine physical examinations and laboratory and diagnostic tests, as required. Special medical services are available either through Specialty Clinic on grounds or through local community providers. The program provides language, speech and hearing assessments, as well as language interpretive services, if needed. A Hospital chaplain provides religious services upon request.

The Pre-Trial Forensic Program is governed by protocols and guidelines for the daily management of defendant-patients so that the services are provided without compromising security. The main security measures include continuously locked wards; check/review by uniformed personnel of all entrants to the program; electronic control of entrance to and from the outside; security personnel; continuous video monitoring of entry and treatment areas; and specialized visitation and escort protocols.

Post-Trial Forensic Rehabilitation Program for the
Guilty Except Insane (GEI)/Not Guilty by Reason of Insanity (NGRI):

The purpose of the post-trial program is to offer treatment services to protect the community and lower recidivism rates while providing patients a safe environment in which to receive psychiatric services. Patients are provided with the opportunity to develop skills to effectively cope with the symptoms of mental illness and receive education and rehabilitative services to enhance community reintegration.

Consisting of two all-male patient care treatment units, the patient population consists of individuals with acute and chronic mental illness, as well as a conviction of Guilty Except Insane or Not Guilty by Reason of Insanity for criminal acts. Patients are admitted from court after forensic commitment with varying degrees of severity of mental illness and level of functioning. When stabilization of mental illness and problem behaviors are achieved, patients are granted increased privileges and independence.

Evaluation, treatment and stabilization in the Post-Trial Forensic Program focuses primarily on the symptoms and interpersonal style that limit the individual patient's from residing safely within the community or in a less restrictive setting. The goal is for the patient to be able to reside in a community setting safely with anticipated outcomes such as:

- Successful coping skills
- Demonstration of compliance with treatment and
- Maintenance of a psychiatrically safe baseline level of behavior and symptoms

The special needs of the patients most often include language barriers and physical/medical issues. The Hospital provides translation services for patients who do not read or understand English under contract to the state. Social workers have the primary responsibility for identifying the resources that are necessary to address the special needs of patients (including sign and other interpreter services).

Due to these patients' complicated legal issues and long length of stay, they are considered to be a high Absent Without Leave (AWOL) risk. Therefore, these patients have more restricted privilege levels, including limited visitation times and searches of materials brought onto the unit by family and friends. Security provides routine unit walk-through and assistance during potentially dangerous situation, as well as assists in unit searches for contraband when evidence warrants.

Community Reintegration Program (CRU)

The purpose of the Community Reintegration Program is to provide post-trial forensic patients with psychiatric rehabilitation services to prepare them to return to the community. Patients either have a **"Conditional Release Plan"** or they are working towards application for Conditional Release.

The Community Reintegration Program is a 32 bed unlocked unit in the Granada Building serving a coed adult forensic population of Guilty Except Insane (GEI) and Not Guilty by Reason of Insanity (NGRI) patients. The average length of stay for patients discharged in Fiscal Year 2002 was 1061 days and average age of 42 and a median age of 43.

A patient can be transferred to Community Reintegration Program from the Post–Trial Forensic Program Units when the following criteria have been met:

1. The treatment team determines the patient is psychiatrically stable and no longer presents a danger to self or to others;

2. The patient is not currently on a conditional release plan to the Hospital, but has been psychiatrically stable for 120 days, have Level III independent grounds privileges, is capable of participating in a self-medication program and is expected to pursue a conditional release plan within 120 days of transfer to Community Reintegration Program;

3. The transfer has been approved by the Special Classification Committee, or

4. The patient has a conditional release plan approved by the Psychiatric Security Review Board (PSRB) or Superior Court.

It is the expectation of the program that patients will be productive citizens once they leave Community Reintegration Program. The program is designed to enable them to acquire the skills necessary to live successfully in the community, e.g., volunteer work, education and paid work.

The Community Reintegration Program offers a variety of therapeutic groups and activities on site and in the community. An individualized group schedule is based upon the needs identified by the patient, the Clinical Treatment Team, the Psychiatric Security Review Board/Superior Court and the Regional Behavioral Health Authority.

Patients are expected to work towards completion of 20 hours of active treatment per week. In addition to unit groups, this can include vocational rehabilitation activities, Arizona State Hospital Work Program, day treatment and school/educational involvement. The groups listed in the Inpatient Treatment and Discharge Plan are mandatory. A consistent pattern of non-compliance or lack of participation in treatment activities will result in review the Community Reintegration

Program Clinical Treatment Team and may be grounds for return to a more restrictive environment or unit. Group attendance is reviewed during Inpatient Treatment And Discharge Plan treatment staffing reviews in order to assess discharge readiness and compliance with Psychiatric Security Review Board conditions. Monthly reports regarding group attendance are sent to Psychiatric Security Review Board so that the board may determine treatment compliance.

Emphasis is on promoting optimal individual functioning, improving adaptive living skills, maximizing community placement opportunities and community safety. Community Reintegration Program patients are progressively earn increased freedom based upon their stability and behavior, so that by the time of discharge to the community, the treatment team has the opportunity to assess how the patient handles increased freedom.

Community case managers and other relevant providers are included in developing the Inpatient Treatment And Discharge Plan. The interdisciplinary clinical team assists the patient with the development of their conditional release plans and the periodic review of the patient's overall progress. The Inpatient Treatment and Discharge Plan is formulated based upon the needs of the patient and the requirements of the Psychiatric Security Review Board/Superior Court. Needs are translated into goals to be achieved during the patient's stay on the Community Reintegration Program unit and subsequent transition to the community. Patient, family and provider input is incorporated into the plan.

The patient population on Community Reintegration Program has more intensive vocational and educational needs that the remainder of the hospital population based upon their discharge ready status back to the community. Hospital staff work with community providers to understand their roles/responsibilities for the monitoring, oversight and management of the Community Reintegration Program patient's high-risk behaviors that led to their hospitalization.

ADOLESCENT TREATMENT PROGRAM

The Adolescent Treatment Program is a co-ed 16-bed unit that operates on a point incentive system in a structured setting. It serves as the admission, assessment and treatment program for adolescents under the age of eighteen (18) who require, on average, approximately three to four months of inpatient treatment as a result of a substantial mental disorder or forensic evaluation.

The point system allows adolescents to receive immediate feedback about their behavior and progress towards treatment plan goals. Earning points allows each adolescent a considerable amount of control over the kinds of privileges he/she receives.

Evaluation, treatment and stabilization on the Adolescent Treatment Unit focuses on psychiatric symptoms, personality characteristics and coping skills that limit the adolescent from residing safely within the community or in a less restrictive setting remain the goals of the program.

Some adolescents under forensic commitments learn legal concepts while their competence to stand trial is restored. The goal is for the patient to be able to reside safely in a community setting or return to family by developing successful coping skills, demonstrating compliance with treatment and maintenance of a psychiatrically safe baseline of behavior and symptoms.

The Adolescent Treatment Unit identifies and assesses children who may be at a special risk due to their age, gender issues, or sexually inappropriate behaviors. Accommodations and program planning on the unit are individualized as much as possible in treating these at-risk youths.

Major treatment modalities include individual and group therapy, family therapy, academic programs, occupational/recreational therapy and psychotropic medications, as appropriate. Onsite education is provided through Maricopa Regional School District in a fully certified special education program. Aftercare planning and placement of the patient are essential components of treatment with active liaison between the Hospital and community providers to assist outpatient service providers in placement and treatment referrals.

A significant challenge facing the Adolescent Treatment Unit is to be responsive to the special needs of individual patients based on their legal status. Patients who are admitted for restoration to competency to stand trial for criminal offences share the same living area with seriously mentally ill adolescents admitted through the civil court process. Special emphasis is placed on the safety and security of the civil patients and the provision of education to patients who are criminally committed.

ADULT PSYCHIATRIC MEDICAL PROGRAM

This 22-bed coed program addresses the psychiatric and medical needs of the general and older adult patients with chronic or acute medical problems, in addition to serious mental illness, to maximize their physical, spiritual and mental well-being, enhance their quality of life and facilitate their return into appropriate community placement.

Patients in this program can be either civil or forensic committed and have been diagnosed with depressive, psychotic or organic disorders and range in age from 39 to 81 years of age. Located on the Granada East Unit, the program is available to provide for the nursing care indicated for sub-acute and chronic medical and post surgical conditions which complicate the patient's primary mental disorder(s).

The unit's goals are to provide psychiatric care and treatment, including medication and medication education, restore physical health as possible, increase the capacity for self-reliance and community living, coordinate discharge planning in collaboration with the behavioral health and other care delivery systems.

- Replace steel piping with copper, install new toilets an install properly vented piping
- Total replacement of electrical system, new wiring, light fixtures, branch circuit wiring, additional receptacles and replace old ones, replace branch circuit panels and upgrade with proper fault current protection

The Maintenance Shop needs a new roof, Americans with Disability Act upgrades, seismic bracing, a new air handling unit, implosion doors on the duct vacuum system, new ductwork, a fire damper, fire sprinkler heads, Americans with Disability Act compliant plumbing fixtures, new electrical service, panels and light fixtures.

The Warehouse needs to be Americans with Disability Act compliant, new roof by 2008, exit and emergency lights, seismic bracing, new ductwork, new evaporative coolers, new air handling system, smoke detectors, fire sprinkler heads for proper coverage, new fire sprinkler piping, new electrical service and panels.

Other Building Concerns

The modular buildings on campus are of combustible construction and are an inefficient use of the site that need to be replaced with conventional construction buildings. The Department of Corrections Motor Pool area and buildings need to be relocated off site. Almost all existing buildings require asbestos containment/removal. The landscaping needs to be revised campus wide, including the entire irrigation system. The Psychiatric Security Review Board, which oversees the Guilty Except Insane patients, needs permanent accommodations.

RECOMMENDATIONS FOR IMPROVEMENT OF THE HOSPITAL

BUDGET ISSUES FOR FY 2004

HEPATITIS C

Hepatitis C viral infection is now of epidemic proportions in the USA. Infectious rates are relatively higher in populations of incarcerated individuals and IV drug abusers. Untreated Hepatitis C infection results in severe medical morbidity and mortality. Current statistics show that approximately 20% of the Arizona State Hospital's patients are Hepatitis C positive. Approximately one-half of these require on going treatment at any one time. With the current level of funding, the Hospital can only afford to treat 10% of the Hepatitis C positive patients.

FORENSIC HOSPITAL RENOVATION

The Hospital has five patient units (Juniper 1, 2, 3, 4, 5) for civil patients who will be moved to the new Civil Hospital buildings scheduled to open in January 2003. The five vacant units were scheduled for renovation in FY 2003 ($80 million appropriated in Laws 2000, Chapter 1, HB 2019) to serve as part of the Forensic Treatment Program. However, due to the state's recent budget crisis, the $10.5 million designated for this renovation was tentatively put on hold in June 2002.

Built in the 1950's, the existing Hospital consists of the Juniper, Wick and Granada Building Units which were never designed to house criminal patients. The Wick Units, which house the current forensic populations, underwent a forensic $2 million upgrade in the 1990's to make them secure, but the five Juniper Units were left in their original condition to serve civil patients.

Without this renovation, the Juniper Units are unsuitable to house forensic/criminal patients, due to lack of appropriate security measures, and will result in an inability to open approximately 112 forensic beds / treatment units. There is a definite need for an increased forensic capacity, as indicated by the implementation of the Restoration to Competency Wait List during the past two years and the approaching implementation of a Guilty Except Insane Wait List sometime within the next fiscal year.

There was an expectation that the referral rate to the forensic program would subside when the counties began to pay 86% of the costs; however, this assumption has not proven to be the case. The demand for forensic services continues to climb and the wait list has had as many as 38 referrals waiting admission to an appropriate bed in the Hospital during the past year.

GUILTY EXCEPT INSANE, MISSING 4TH DISPOSITION

Formerly known as "Not Guilty by Reason of Insanity", the law in Arizona changed in 1994 to "Guilty Except Insane" and defendants sentenced under the statute were given determinate sentences to the Hospital and are under the jurisdiction of the Psychiatric Security Review Board. The law prescribes Psychiatric Security Review Board actions that must be taken when a Guilty Except Insane patient is:

1. No longer mentally ill, and not dangerous (RELEASED)
2. Mentally ill, and still dangerous (REMAINS CONFINED)
3. Mentally ill, and no longer dangerous (CONDITIONALLY RELEASED)

However, for the following category of Guilty Except Insane the statute is silent and the Psychiatric Security Review Board has no mechanism or authority to oversee the defendant in the community, nor the statutory ability to assign responsibility to any other agency (as is the case in other states), for example, to the department of corrections parole board:

4. No longer mentally ill, but still dangerous (STATUTE IS SILENT) - and therefore, the defendant remains at the Hospital, even though there is no treatment we can provide, because the Psychiatric Security Review Board is concerned about the public's safety. There is no mechanism through which to release this person (say to a parole authority). These patients tend to be manipulative and disruptive to current programs and to the vulnerable seriously mentally ill patients under our care.

This is not to imply the person was not mentally ill at one time, but the person exhibits no current symptoms of mental illness. Some of these individuals may not have met the statutory criteria for admission, but the Hospital continues to work with the courts and the counties to ensure that those involved in the commitment process are currently aware of the admission criteria (which does not include sociopathic behavior or primarily substance abusers). This emphasis on education has gone a long way in the past year to encourage admissions where the Hospital can play a key role in treatment, however it has not addressed what to do with those who are no longer mentally ill, but still dangerous. The Psychiatric Security Review Board is reluctant to act without statutory guidance, out of concern for the public's welfare.

Precious bed space and resources are spent on persons who do not require psychiatric care. The Hospital agrees with the Psychiatric Security Review Board that a solution to this dilemma needs to be decided by policy makers upon review of the current Guilty Except Insane laws.

The Guilty Except Insane population has been the Hospital's fastest growing population during the past several years, which is complicated by the determinate sentences involved. The average length of stay for Guilty Except Insane patients was over 1000 days this past fiscal year, versus 180 - 270 days for civil patients. These patients are here a much longer duration, and the trend appears to be rising.

Keeping people confined at the Hospital who do not require our services at the current time (at an average cost of $401 per day) is problematic. The challenge, however, is to draft a law that is constitutional. The Hospital is working with representatives from the counties and the courts to come up with a constitutional solution.

Compensation

Nursing – Current compensation of critical direct care nursing positions at the Arizona State Hospital is non-competitive with both the private sector and other public agencies. Turnover data reflects a significant amount of employees in these positions are attracted to higher wage comparable positions at other facilities. This has lead to significant recruitment and retention problems making it difficult to meet the needs of the patients, including safety, security, active treatment, and a therapeutic environment and to meet national / state regulatory standards.

Rehabilitation, Social Work, Psychology, and Psychiatry – Compensation is non-competitive with the private sector and other governmental agencies. This has lead to increased staff vacancies and high turnover in direct care positions.

Finance – Several key finance positions cannot be filled due to low grade/pay as compared to equivalent positions in the market, these positions need to be re-classed. Overall the workload and complexity has increased for the Finance Office due the statutory requirement to bill counties for 86% of the costs for the Restoration to Competency.

Security – Compensation is non-competitive with both the private sector and other governmental agencies. Significant turnover has lead to recruitment and retention problems.

Arizona Community Protection and Treatment Center Annualization

During the 2000 legislative session, funds were appropriated for a decision package related to growth of the Sexually Violent Person program. $2,173,800 was included in the Sexually Violent Person line item for the additional growth. This amount represented funding for 9 months. In the subsequent fiscal year, FY 2001-2002, the annualization adjustment for the amount previously appropriated was not made.

Drug Costs

The so-called newer generation atypical psychotropic medications, while much more expensive than their predecessors, have played a key role in enabling the Hospital to evolve from a warehousing institution of the 1950's (with over 1500 patients) to being a true treatment facility in the year 2002 (with only 335 licensed beds), with patients returning to the community within 6 - 8 months to lead more normal lives. It was not until the 1990's that this dramatic breakthrough in psychiatry came about.

Pharmacy drug costs are increasing at an alarming rate. Literature projects that there will continue to be a 20-22% increase in drug costs each year. While the costs of the newer generation medications is high, it must be weighed against the costs of keeping people in confinement, which in the past, often meant decades of hospitalization. Not to mention the human costs of diminished capacity to lead normal lives.

DIETARY, ENGINEERING AND GROUNDS KEEPING

Some equipment used by support services is outdated and inefficient to meet the needs of the hospital. It is difficult to find replacement parts for some pieces of equipment. By updating and adding various equipment used by Dietary, Engineering and Grounds Keeping the increased efficiency will free up manpower time allowing workers to get more projects complete, better meeting licensure and accreditation environmental and safety requirements.

ANNUALIZATION OF 16 POSITIONS

The Arizona State Hospital was appropriated 16.0 new FTE's in FY2003 to support opening of the new civil behavioral health hospital facility. The positions were phased, requiring partial funding during FY2003. The department is requesting annualization of these positions in FY2004 to support full funding levels.

AUTOMATED DRUG DISPENSING MACHINES

Install Automated Drug Dispensing Machines on each unit in the hospital to improve overall patient care, efficiency and safety. The Hospital annually reviews the drug formulary and engages in on-going education to ensure safe ordering practices. Clinical practice guidelines are followed. After extensive review, the Patient Safety Committee recommended the use of Automated Drug Dispensing Machines to limit access to targeted high risk drugs (such as insulin and lithium which come in varying doses and look alike packages that can be administered incorrectly and carry a higher risk of medication error).

Environment of Care Issues

Throughout the Hospital planning process for the new Hospital, interim life safety measures have been implemented. Proactive risk assessments have been conducted, including hazard surveillance and insuring that infection control measures meet the AIA standards.

In conjunction with local community hospitals and community wide organizations, the Hospital is involved in "Emergency Management Planning" to develop bioterrorism plans and a "Business Continuity Disaster Recovery Plan". The Hospital needs to have a viable evacuation plan in place and be prepared to assist other

local agencies should the need arise. At this time, the Hospital lacks a hospital-wide public address system and the necessary radio controlled devices in order to respond in such an emergency.

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